ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES

150 N. 18th Avenue, # 450 Phoenix, Arizona 85007 *** 400 W. Congress Tucson, Arizona 85701

RENEWAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

Name of health care institution		License number
Mailing address		
City	State	Zip code
Telephone number	Fax number	E-mail address
Health care institution class or subclass:		

II. OWNER INFORMATION

Owner's name		
Address		
City		Zip code
Telephone number		Fax number
The owner is a: (check one)	_____Proprietary	_____Non-proprietary
The owner is a: (check one)	_____Sole proprietorship	_____Partnership
_____Limited liability company	_____Corporation	_____Governmental Agency

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:
If the owner is a partnership, the name of each partner;
If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
If the owner is a corporation, the name and title of each corporate officer; or
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name	Title
Name	Title
Name	Title
Name	Title

B. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended since the last application was submitted?
____Yes ____ No.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended since the last application was submitted?
____Yes ____ No.

D. If either of the previous questions is answered yes, include on a separate sheet of paper for each yes answer:
1. The reason for the denial, suspension, or revocation;
2. The date of the denial, suspension, or revocation;
3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. § 36-422(B) the application must be signed, as follows:

(1) If an individual, by the owner of the institution;
(2) If a partnership or corporation, by two of the partners or corporate officers; or
(3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

_____ _____
Signature Date Signature Date

_____ _____
Title Title

STATE OF_____) STATE OF_____)

COUNTY OF _____) COUNTY OF _____)
Subscribed and sworn to before me this Subscribed and sworn to before me this

_____ day of _____, _____ day of _____,

by by
Notary Public Notary Public
My Commission Expires My Commission Expires

For DHS use only: Correct application fee enclosed: _____ Yes _____ No Check #:

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of Licensing Services
Office of Medical Facilities Licensing

150 North 18th Avenue, Suite 450 - Phoenix, Arizona 85007
400 West Congress, Suite 116 - Tucson, Arizona 85701

HEALTH CARE INSTITUTION APPLICATION AND RENEWAL LICENSE FEE REMITTANCE FORM

PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE

FACILITY I.D. #:	LICENSE #:	LEVEL OF CARE OR SERVICES
APPLICANT/ENTITY NAME:		
FACILITY NAME:		
PHYSICAL STREET ADDRESS:	SUITE #:	
CITY:	STATE:	ZIP:
MAILING ADDRESS:		
CITY:	STATE:	ZIP:

FEES	**AMOUNT DUE**
Application Fee (Please do not submit the application fee if the fee has already been paid.)	**$ 50.00**
LICENSED CAPACITY	

Check One:	**Licensed Capacity:**	**Base Fee:**	**Number of Beds x $10.00 each:**	**Total base fee plus number of beds fee:**
	None	$100.00		
	1 to 59 beds	$100.00		
	60 to 99 beds	$200.00		
	100 to 149 beds	$300.00		
	150 or more beds	$500.00		

TOTAL AMOUNT DUE	$

Payment should be by cashier's check, money order or business check made payable to:
ARIZONA DEPARTMENT OF HEALTH SERVICES

Write the Facility I.D. # or Facility License # on the check.
Cash and personal checks are not accepted.

AMOUNT ENCLOSED	$

ALL FEES ARE NON-REFUNDABLE pursuant to A.R.S. ' 36-405(c), 36-882(f) and 36-897.01(c), except as provided in A.R.S. ' 41-1077.